

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150030	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/02/2012
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NAME OF PROVIDER OR SUPPLIER  HENRY COUNTY MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 N 16TH ST NEW CASTLE, IN 47362
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S0000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005028</p> <p>Survey Date: 4-30/5-2-12</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Deborah Franco, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson Medical Surveyor</p> <p>QA: cloughlin 05/10/12</p> <p>6/22/12 revised due to IDR</p>	S0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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S0178	<p>410 IAC 15-1.3-2 POSTING OF LICENSE 410 IAC 15-1.3-2(a)</p> <p>(a)The license shall be conspicuously posted on the hospital premises in an area open to patients and public. A copy shall be conspicuously posted in an area open to patients and public on the premises of each separate hospital building of a multiple hospital building system.</p> <p>Based on observation, the hospital failed to conspicuously post the hospital license in an area open to patients and the public.</p> <p>Findings:</p> <p>1. On 5-1-12 at 10:40 am in the presence of employee #A4, it was observed in the Forest Ridge Medical Pavilion offsite, there was not a copy of the hospital's license posted at the entry to the first floor where the pool and gymnasium were located.</p>	S0178	<p>On 5/03/2012, the hospital license was conspicuously posted near the first floor entry of Forest Ridge Medical Pavilion where the pool and gymnasium are located. This area is open to patients and the public as required by 410 IAC 15-1.3-2(a). The Hospital Regulatory Director will be responsible to ensure a copy of the hospital license is conspicuously posted at Forest Ridge Medical Pavilion at the first floor entry and in all other appropriate entrances.</p>	05/03/2012	

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S0270	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(6)</p> <p>(a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following:</p> <p>(6) Review, at least quarterly, reports of management operations, medical staff actions, and quality monitoring, including patient services provided, results attained, recommendations made, actions taken and follow-up.</p> <p>Based on document review and interview, the governing board failed to review 1 service included in the facility's quality assurance and performance improvement (QAPI) program for calendar year 2011.</p> <p>Findings:</p> <p>1. Review of governing board minutes for calendar year 2011 indicated there was no review of the facility's electroencephalography (EEG) service.</p> <p>2. In interview, on 5-2-12 at 1:45 pm, employee #A7 indicated there was no documentation of the governing board having reviewed quality activities in calendar year 2011 for the EEG service. No documentation was provided prior to exit.</p>	S0270	<p>On 5/14/2012 the Respiratory Department Quality Assurance and Performance Improvement Program (QAPI) was updated to include monitoring of the electroencephalography (EEG) service. A QAPI indicator was created that will monitor EEG report turnaround times. We will look specifically at the transmittal of the test, the dictation and availability of the report on the patient record. The data will be collected monthly and reported through the Nursing Performance Improvement quarterly meeting and shared with staff at department meetings. Compliance results will be forwarded to the Performance Improvement Committee to ultimately be presented to the hospital operating board for review. The acceptable compliance threshold in regards</p>	05/14/2012			

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			to this test turnaround time of 3 days from test completion to dictation and posting of report will be 90%.The Respiratory Department Director as well as the Respiratory Clinical Coordinator will be responsible for ensuring the indicator is within the expected threshold.	

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S0406	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and interview, the hospital failed to include standards for 1 contracted service as part of its QAPI program.</p> <p>Findings:</p> <p>1. Review of the facility's QAPI program indicated it did not include standards for the contracted service of electroencephalography.</p> <p>2. In interview, on 5-2-12 at 1:45 pm, employee #A7 indicated there was no documentation of standards for the contracted service of electroencephalography and no documentation was provided prior to exit.</p>	S0406	<p>On 5/14/2012 the Respiratory Department Quality Assurance and Performance Improvement Program (QAPI) was updated to include monitoring of the contracted electroencephalography (EEG) service. A QAPI indicator was created that will monitor EEG report turnaround times. We will look specifically at the transmittal of the test, the dictation and availability of the report on the patient record. The data will be collected monthly and reported through the Nursing Performance Improvement quarterly meeting and shared with staff at department meetings. Compliance results will be forwarded to the Performance Improvement Committee to ultimately be presented to the hospital operating board for review. The acceptable</p>	05/14/2012	

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			compliance threshold in regards to this test turnaround time of 3 days from test completion to dictation and posting of report will be 90%.The Respiratory Department Director as well as the Respiratory Clinical Coordinator will be responsible for ensuring the indicator is within the expected threshold.		

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S0556	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(b)</p> <p>(b) There shall be an active, effective, and written hospital-wide infection control program. Included in this program shall be system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers.</p> <p>Based on document review and interview, the facility failed to provide an effective infection control program to prevent the spread of communicable diseases in patients and health care workers for 11 of 11 (P1-P11) personnel records reviewed.</p> <p>Findings included:</p> <p>1. Immunization of Health Care Workers: Recommendations of the Advisory Committe on Immunization Practices (ACIP) and the Hospital Infection Control Practices Advisory Committee states, "Because of their contact with patients or infective material from patients, many health-care workers (HCWs) (e.g. physicians, nurses, emergency medical personnel, dental professionals and students, medical and nursing students, laboratory technicians, hospital volunteers, and administrative staff) are at</p>	S0556	<p>On 5/22/2012 the Infection Control /Employee Health Policy 7.2 was updated to indicate the new hire process for all Henry County Hospital Employees will involve obtaining the following blood titers on each new hire at the facility: · Rubeola · Varicella · Rubella · Hepatitis B antibody (on those employees with expected exposure to blood or body fluids) All existing employees of Henry County Hospital will be tested within the next 3 months for the following blood titers to update their employee health files and prove immunity to these diseases: · Rubeola · Varicella · Rubella – This titer has already been obtained on existing Henry County Hospital employees · Hepatitis B antibody titers have already been obtained on existing Henry County Hospital employee's category 1 and 2. The medical portion of each employee's health record will be updated with the testing</p>	05/22/2012

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	<p>risk for exposure to and possible transmission of vaccine-preventable diseases. Maintenance of immunity is therefore an essential part of prevention and infection control programs for HCWs. Opimal use of immunizing agents safeguards the health of workers and protects patients from becoming infected through exposure to infected workers".</p> <p>2. Facility policies "Employee Health Records", last reviewed/revised 10-18-2011 provided that " The employee health record will consist of the following information: The initial new employee physical form, Rubella titer/vaccination record, Hepatitis titer/vaccination, New Hire-Mantoux skin test results/chest x-ray results and Tuberculosis assessment forms, Exposure Risk Category, Drug testing" .</p> <p>3. Review of personnel files on 5-2-2012 lacked evidence that 11 of 11 staff members (P1- P11) had documented reliable proof of immunity to Rubeola.</p> <p>4. Review of personnel files on 5-2-2012 lacked evidence that 11 of 11 staff members (P1-P11) had documented reliable proof of immunity to Varicella.</p> <p>5. During interview with S1 on 5-2-2012</p>		<p>information and a computerized data base available on each employee to indicate the immunity status of all employees at Henry County Hospital to these diseases. This will provide efficient and convenient access to the laboratory confirmed immunity status of all Henry County Hospital employees. The Director of Infection Control will be responsible to ensure each new employee has a blood titer obtained on each of the following: Rubeola, Varicella, and Rubella (and Hepatitis B antibody on those employees with expected exposure to blood or body fluids). The Director of Infection Control will also be responsible to ensure all existing employees have their immunity to Rubeola, Varicella, and Rubella proven within the next three (3) months. See Attachment 1 for updated Policy.</p>				

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	<p>at 12 noon S1:</p> <p>a. verified the above findings of lack of reliable documented proof of immunity to Varicella and Rubeola in employees P1-P11.</p> <p>b. indicated that facility policy does not require reliable documented proof of immunity to Rubeola or Varicella for its employees.</p> <p>c. indicated the facility lacked a policy to prevent secondary spread of communicable diseases by employees in the event of a community outbreak of Rubeola or Varicella.</p> <p>d. indicated the facility follows CDC recommendations and that as Infection Control Preventionist, S1 was not aware that self-attestation by employees as proof of immunity to Rubeola and Varicella was not considered documented reliable proof of immunity per CDC guidelines.</p>				

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S0610	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(x)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following:</p> <p>(AA) Storage of employee food in patient refrigerators.</p> <p>(BB) Medications in nutrition refrigerators.</p> <p>(CC) Refrigerator and freezer temperature monitoring.</p> <p>Based on document review, the hospital failed to follow its policy to report any temperature discrepancies to Maintenance as soon as possible in 9 of 14 instances and failed to record the freezer temperatures in 14 of 14 instances.</p> <p>Findings:</p> <p>1. Review of a document entitled</p>	S0610	On 5/21/2012, Henry County Hospital Infection Control Manual Housekeeping, Section 11.5, Refrigeration Care was updated to indicate Housekeeping personnel must document on the Refrigerator/Freezer temperature log the date and time maintenance is contacted regarding a temperature discrepancy in a refrigerator or freezer. On 5/22/2012 the	05/21/2012	

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	<p>HENRY COUNTY HOSPITAL INFECTION CONTROL MANUAL HOUSEKEEPING, Section : 11.5 REFRIGERATION CARE, revised 7-19-11, indicated normal ranges are as follow: Refrigerator - 32 to 39 F and Freezer - 10 F to 0 F and any temperature discrepancies will be reported to Maintenance as soon as possible.</p> <p>2. Review of a document entitled Refrigerator/Freezer Temperature Log, for the Sleep Lab for the period January through April, 2012, indicated there were 14 days the department was open and 9 times refrigerator temperatures were recorded greater than 39 F. There was no documentation indicated on the document that the temperature discrepancies had been reported to Maintenance as soon as possible.</p> <p>3. In interview, on 5-1-12 at 10:05 am, hospital staff indicated they were not knowledgeable if the discrepancies had been reported to Maintenance and no other documentation was provided prior to exit.</p> <p>4. Review of a document entitled Refrigerator/Freezer Temperature Log,</p>		<p>revised Refrigeration Care policy was reviewed by all housekeeping employees. On 5/22/2012 housekeeping personnel were re-educated on the updated policy and existing policy standards including: 1) temperatures must be recorded on a weekly basis for both the refrigerator and the freezer; 2) maintenance must be contacted as soon as possible regarding any temperature discrepancy on the refrigerator or freezer in which temperatures fall outside of the "normal range"; and 3) personnel must document in the temperature log the date and time maintenance was contacted regarding a temperature discrepancy. The Director of Housekeeping will be responsible to monitor and ensure the updated Refrigeration Care policy is followed by all housekeeping personnel. See Attachment 2 for updated Policy.</p>				

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	<p>for the Sleep Lab for the period January through April, 2012, indicated there were 14 days the department was open and no times freezer temperatures were recorded.</p> <p>5. In interview, on 5-1-12 at 10:05 am, hospital staff indicated there no other documentation of freezer temperatures for the period January through April 12 and no other documentation was provided prior to exit.</p>				

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S0744	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(1)</p> <p>(e) All entries in the medical record shall be:</p> <p>(1) legible and complete;</p> <p>Based on document review and interview, the facility failed to assure the completeness of the medical record for 3 of 30 (N1, N10, and N29) medical records reviewed.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. Review of medical record N1 contained a surgical consent form which lacked signature and date by the employee witness.</li> <li>2. Review of medical record N10 contained a blood consent form which lacked signature and complete date by the employee witness. N#10 received 6 transfusions during this admission.</li> <li>3. Review of medical record N29 contained a transfer form which lacked signature of the RN, date and time patient released, and final vital signs.</li> <li>4. Facility policy for completeness of medical records was requested on 5-1-2012 and none was provided prior to</li> </ol>	S0744	<p>(1) On 03/02/2011 Surgical Consent for a Colonoscopy was accepted missing the Date and Time the consent was signed. It is the responsibility of the circulator to make sure all information on consents is correct and completed. On 5/21/2012 circulators and same-day surgery nurses were re-educated on making sure all consents are completed. Consent completeness will be monitored through Surgery Clinical Pertinence document reviews. Compliance results will be reported through the Nursing PI/Clinical Pertinence meetings, shared with staff at unit meetings, as well as forwarded on to the medical staff during the P.I. Committee meetings, and ultimately to the Board. The acceptable compliance goal = 100% The Surgery Directors will be responsible for ensuring all consents are correct and completed. (2) During the week of 5/21/2012 extensive education was completed with all PCU staff at the PCU unit meetings on the need for all blood consents to have completed signatures and completed dates and times. This</p>	05/21/2012	

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	<p>exit.</p> <p>5. During interview with S5 on 5-2-2012 at 11:00 AM, S5 verified the above findings and indicated that the medical records were not completed in conformance with facility policy.</p>		<p>education included the need for a complete signature, date (month, day and year), and time. Blood consent signature, date and time compliance will be monitored through PCU PI by the PCU director, clinical manager, and charges nurses. Compliance results will be reported through the Nursing PI/Clinical Pertinence meetings, shared with staff at unit meetings, as well as forwarded on to the medical staff during the P.I. Committee meetings, and ultimately to the Board. The acceptable compliance goal is 100% The PCU Department Director, Clinical Manager, and Charge Nurses will be responsible for ensuring all blood consents are complete. (3) During the week of 5/21/2012 the Emergency Department staff was educated on the necessity to complete all blanks on the Transfer Form. Education was provided via e-mail and a visual transfer form with all required blanks highlighted was displayed in a staff-only area in the department. During the May staff meeting, the transfer form and the required fields were reviewed. Completion of transfer forms will be monitored via Emergency Department clinical pertinence document reviews. Compliance results will be reported through the Nursing PI/Clinical Pertinence meetings, shared with staff at unit meetings, as well as forwarded on to the medical staff during the</p>		

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			P.I. Committee meetings, and ultimately to the Board. The acceptable compliance goal will be 90%. The Emergency Department Director will be responsible for monitoring compliance and ensuring staff are meeting the 90% compliance goal. See Attachment 3 for Hospital's policy on Completeness of Medical Records for Outpatients, Observation, and Inpatient Services.		

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S0872	<p>410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(b)(3)(P)</p> <p>(b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall: (3) include, but not be limited to, the following:</p> <p>(P) A requirement that the the final diagnosis be documented along with completion of the medical record within thirty (30) days following discharge.</p> <p>Based on document review and interview, the facility failed to assure that medical records were completed within 30 days for 2 of 30 (N9 and N25) medical records reviewed.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. Medical Staff Bylaws, page 12, 11. "Record completion...All Medical Staff members and all Allied Health Care Providers are required to complete medical records within 30 days after discharge or outpatient service date or they will be considered delinquent".</li> <li>2. Review of the medical record of N9 included an order dated 7-1-2011 which was authenticated by the physician on 8-12-2011. The patient was discharged 7-8-2011.</li> </ol>	S0872	<p>According to Henry County Memorial Hospital Medical Staff Bylaws, all Medical Staff Members and all Allied Health Care Providers (hereinafter referred to as "practitioners") are required to complete medical records within thirty (30) days after discharge or outpatient service date or the medical record will be considered delinquent. The Medical Records Department is responsible to monitor the status of Practitioner compliance with medical record documentation requirements. The Medical Records Department notifies practitioners biweekly of incomplete records. The Medical Records Department must inform the Medical Executive Committee of any practitioners who fail to complete medical records within 30 days. The Medical Executive Committee then has discretion to take action against the</p>	05/28/2012	

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	<p>3. Review of the medical record of N25 included a Discharge/Death Summary authenticated by the physician on 3-3-2012. The patient died on 1-1-2012.</p> <p>4. During interview with S5 on 5-2-2012 at 11:00 AM, S5 verified the above findings and indicated that the medical records were not completed in conformance with facility policy.</p>		<p>practitioner. The acceptable compliance goal is 100%. Compliance with completeness of medical records is reported to and reviewed by the Medical Review Committee. On May 28, 2012 the Medical Staff will receive education via email from the Medical Staff Chief of Staff advising them of their responsibility to complete all medical records within thirty (30) days of discharge or outpatient service and of potential consequences for practitioners who fail to meet this requirement. The Medical Staff will also be educated on the compliance goal. The Director of Medical Records is responsible to monitor compliance and ensure all practitioners meet the compliance goal.</p>		

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S1172	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C)</p> <p>(e) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, shall be kept clean and orderly in accordance with current standards of practice as follows:</p> <p>(1) Environmental services shall be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following:</p> <p>(A) Asepsis (B) Cross-infection; and (C) Safe practice.</p> <p>Based on observation, document review and interview, the hospital failed to keep the floors clean and orderly in the laundry areas and failed to disinfect contact isolation rooms with the facility approved disinfectant and according to approved infection control procedures on 2 of 2 medical surgical units (PCU West and Medical Surgical Unit 1) toured.</p> <p>Findings:</p> <p>1. On 4-30-12 at 1:20 pm, in the presence of employee #A4, it was observed in the clean, dirty and storage areas of the laundry, there was a considerable amount of lint, dust and debris on the floors.</p>	S1172	<p>(1) It is the policy of Henry County Memorial Hospital that the entire laundry area be cleaned on a daily basis. The daily cleaning of the laundry area includes dust mopping or vacuuming and picking up all litter from the floor with a counter brush and dustpan. On 5/11/2012 the Director of Housekeeping educated the housekeeping personnel who are responsible to clean the laundry area of their responsibility to follow all procedures stated in the laundry cleaning policy when cleaning the laundry area. The Director of Housekeeping will be responsible to ensure the laundry department is cleaned on a daily basis, including adequate cleaning of</p>	05/11/2012
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			<p>the entire floor. (2) It is the policy of Henry County Memorial Hospital that the housekeeping personnel must use a bleach solution when cleaning C. Difficile contact isolation rooms. On 5/11/2012, housekeeping personnel were required to attend an inservice with the Director of Infection Control. The Director of Infection Control reviewed the isolation room cleaning procedures and further educated the housekeeping personnel on the following: 1) a bleach solution must be used when cleaning a C. Difficile contact isolation room; 2) Wexcide 128 is not a bleach solution and is not adequate to clean a C. Difficile contact isolation room; 3) the entire room (including all equipment, bed, floors, windows, ceilings, curtains, etc.) and restroom area must be cleaned with a bleach solution in a C. Difficile contact isolation room; 4) Dispatch is a an EPA approved bleach solution and is an adequate solution to use when cleaning a C. Difficile contact isolation room; 5) any soiled draperies must be placed in a clear plastic laundry bag and washed in a bleach solution; and 6) any soiled ceiling tiles must be reported to maintenance. Dispatch cleaning towels were ordered on 5/11/2012 and were placed on all housekeeping carts as soon as they are received to ensure housekeeping personnel who clean C. Difficile contact</p>	

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	<p>2. Facility policy "Isolation Terminal Cleaning", last reviewed/revised 4-20-2010, provided "If contact isolation for C. Difficile use bleach solution. Clean all equipment and place by door, IV poles, isolation racks, commodes, etc. Clean and inspect ceiling tiles for dust, damage, or soiling....Dust mop and wet mop the floor from the inside of the room and work toward the door...".</p> <p>3. During interview with staff housekeeper S3 while on tour of Medical Surgical Unit 1 on 5-2-2012 at 10:05 AM and in the presence of S5, S3 indicated:</p> <p>a. C. Difficile contact isolation rooms are terminally cleaned with Wexcide 128 solution the same as any other terminal</p>		isolation rooms will always have an adequate bleach solution available to clean the isolation room. The Director of Housekeeping will monitor housekeeping personnel while cleaning C. Difficile contact isolation rooms to ensure a bleach solution is used and the entire area is cleaned according to Hospital policies and procedures. The Director of Housekeeping will be responsible to ensure all C. Difficile contact isolation rooms and restrooms are cleaned using an adequate bleach solution (Dispatch). See Attachments 4 and 5 for applicable Hospital policies.				

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	<p>cleaning of a room when patient is discharged.</p> <p>b. last week a patient was discharged from room 238 who had been on contact isolation for stool C. Difficile and the room was cleaned with Wexcide 128.</p> <p>4. During interview with staff housekeeper S4 while on tour of PCU on 5-2-2012 at 10:10 AM and in the presence of S5, S4 indicated:</p> <p>a. C. Difficile contact isolation rooms are terminally cleaned with Wexcide 128 solution the same as any other terminal cleaning of a room when patient is discharged.</p> <p>b. that if curtains were visibly soiled in a C. Difficile contact isolation room the drapes would be cleaned with Wexcide 128.</p> <p>c. used Dispatch ( a bleach solution) only to clean the bathrooms in C. Difficile contact isolation rooms; if curtains were visibly soiled they would be cleaned in place with Wexcide 128.</p> <p>5. During interview with Director of Housekeeping, S6 on 5-2-2012 at 10:10 AM, S6 indicated:</p> <p>a. housekeeping employees receive annual training each year on infection control practices requiring the use of bleach rather than Wexcide 128 for C. Difficile patients.</p>			

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	<p>b. performs spot inspections of the cleanliness of rooms but does not inspect housekeepers during their terminal cleaning procedures to ascertain what disinfectants are used; the order in which the room is terminally cleaned; whether the ceiling has been inspected for dust or soiling; or the time period the disinfectants are left in contact with surfaces prior to drying.</p> <p>c. did not know why 2 of 2 housekeepers interviewed on the medical surgical units regarding terminal cleaning practices were using the incorrect chemical for disinfection of C. Difficile contact isolation rooms.</p>			

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S1186	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E) (i)(ii)(iii)(iv)(v)</p> <p>(f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following:</p> <p>(A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety. (D) Hazardous materials and wastes management in accordance with federal and state rules. (E) A written fire control plan that contains provisions for the following: (i) Prompt reporting of fires. (ii) Extinguishing of fires. (ii) Protection of patients, personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting authorities.</p> <p>Based on document review and interview, the facility failed to follow its policies to conduct fire drills for 2 of 4 quarters at an offsite in calendar year 2011.</p> <p>Findings:</p> <p>1. Review of the hospital's State license indicated the Forest Ridge Medical Pavilion is a provider-based off-site location.</p> <p>1. Review of a facility document entitled</p>	S1186	<p>On 5/2/2012, Forest Ridge Medical Pavilion Safety Management Manual, "Life Safety Management Plan: Fire Drill Procedures" was updated to read "To evaluate the pavilion's fire fighting procedures there will be a minimum of one fire drill per quarter...Each quarter, Forest Ridge Maintenance will cause the fire system to activate both audibly and visually..." The quarterly fire drill will be documented by the Forest Ridge Maintenance Supervisor on a "Fire Alarm Activation/Drill</p>	05/02/2012			

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	<p>FOREST RIDGE MEDICAL PAVILION SAFETY MANAGEMENT MANUAL, Section: Life Safety Management Plan, Subsection: Fire Drill Procedures, last reviewed 1-11, indicated all Fire Drills will be conducted per State and Local codes or procedures.</p> <p>2. Review of a facility document entitled HENRY COUNTY HOSPITAL SAFETY MANAGEMENT MANUAL, Section: Life Safety Management Plan, Subsection: Fire Drill Procedures, last reviewed 1-11, indicated to evaluate the hospitals fire fighting procedures there will be a minimum of one fire drill per quarter per shift.</p> <p>3. Based on the above documentation, the Forest Ridge Medical Pavilion, being a provider-based off-site location, is subject to all Henry County Memorial Hospital policies and procedures. Thus, there must be a minimum of one fire drill per quarter per shift performed at the Forest Ridge Medical Pavilion.</p> <p>4. In interview, on 5-2-12 at 11:45 am, employee #A6 indicated there were only 2 fire drills conducted at the Forest Ridge Medical Pavilion, March 25, 2011 and June 30, 2011. No other documentation was provided prior to exit.</p>		<p>Evaluation Report." The results of the fire drills will be evaluated and reported to the Safety Committee Meetings on a quarterly basis. The Forest Ridge Maintenance staff has been educated on the policy change. The Directors of Safety and Maintenance will be responsible for ensuring fire drills are performed on a quarterly basis. See Attachment 6 for updated Policy.</p>	